S. 2759

At the request of Mr. SMITH, the name of the Senator from Ohio (Mr. DEWINE) was added as a cosponsor of S. 2759, a bill to provide for additional outreach and education related to the Medicare program and to amend title XVIII of the Social Security Act to provide a special enrollment period for individuals who qualify for an income-related subsidy under the Medicare prescription drug program.

S. RES. 320

At the request of Mr. ENSIGN, the names of the Senator from New York (Mrs. CLINTON) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. Res. 320, a resolution calling the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide.

S. RES. 436

At the request of Mr. MCCAIN, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. Res. 436, a resolution urging the Federation Internationale de Football Association to prevent persons or groups representing the Islamic Republic of Iran from participating in sanctioned soccer matches.

S. RES. 469

At the request of Mr. LIEBERMAN, the name of the Senator from Connecticut (Mr. DODD) was added as a cosponsor of S. Res. 469, a resolution condemning the April 25, 2006, beating and intimidation of Cuban dissident Martha Beatriz Roque.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

Mr. DODD (for himself and Mr. SMITH):

S. 2765. A bill to provide assistance to improve the health of newborns, children, and mothers in developing countries, and for other purposes; to the Committee on Foreign Relations.

Mr. President, I rise today to introduce, on behalf of myself and my friend, Senator GORDON SMITH of Oregon, the Child Health Investment for Long-term Development (CHILD and Newborn) Act of 2006. This legislation would perform four simple, yet critically important functions.

First, it would require the Administration to develop and implement a strategy to improve the health of, and reduce mortality rates among, newborns, children, and mothers in developing countries.

Second, it would mandate the establishment of a U.S. Government task force to assess, monitor, and evaluate the progress of U.S. efforts to meet the United Nations Millennium Development Goals by 2015—specifically as those goals relate to reducing mortality rates for mothers and for children less than 5 years of age in developing countries.

Third, it would authorize the President to furnish assistance for programs whose goal is to improve the health of newborns, children, and mothers in developing countries.

And fourth, this legislation would authorize appropriations to carry out its provisions—$660 million for fiscal year 2007, and $1.2 billion for each of fiscal years 2008–2011.

I know that some of my colleagues will look at this bill and ask why the U.S. should devote such large amounts of resources to combating child and maternal mortality in the developing world. Certainly, nobody would deny that it's an important cause, but should it really be this much of a priority?

I would argue that the answer to this is yes. Why? Because with U.S. leadership, the current reality for mothers and their young children in the developing world can be changed dramatically.

What is that reality?

Almost 11 million children under the age of 5 die every year in the developing world—that's approximately 30,000 each day. About four million of those children die in their first four weeks of life. In many cases, they aren't even provided with a fighting chance. Indeed, for children under the age of five in the developing world, preventable or treatable diseases such as measles, tetanus, diarrhea, pneumonia, and malaria are the most common causes of death.

Each year, more than 525,000 women die from causes related to pregnancy and childbirth—more than 1,400 each day. Ninety-nine percent of these deaths occur in the developing world. And the lifetime risk of an African woman dying from a pregnancy or childbirth-related complication is I in 16, a high level of risk that is all the more striking when compared to the same risk for women in more developed regions—1 in 2,800. Some of the most common risk factors for maternal death in developing countries include early pregnancy and childbirth, closely spaced births, infectious diseases, malnutrition, and complications during childbirth.

Mr. President, the deaths of these nearly 12 million mothers and children are from largely preventable causes. This is a tragic situation, and it shouldn't be the case.

Luckily, we can combat these high levels of mortality—and it won't require lots of sophisticated technology. Instead, it will require simple measures that we take for granted here in the developed world.

For instance, it is estimated that two-thirds of deaths among children under 5 years of age—that's 7.1 million children, including 3 million newborns—could be prevented by low-cost, low-tech health and nutritional interventions. These interventions include encouraging breastfeeding; providing vitamin supplements, immunizations, and antibiotics; offering oral rehydration therapy with clean water; and expansion of basic clinical care.

For expecting mothers, simple steps such as birth spacing, access to preventive care, skilled birth attendants, and emergency obstetric care can help reduce maternal morality rates. And keeping mothers healthy is critical because the welfare of newborns and infants is inextricably tied to the health of the mother.

Mr. President, the U.S. isn't new at this battle. Over the past 30 years, our work in promoting child survival and maternal health globally has resulted in millions of lives being saved.

And in 2000, the U.S. joined 188 other countries in supporting eight Millennium Development Goals laid out by the United Nations. Two of these goals are related to child and maternal health—one calls for a reduction by two-thirds in the mortality rate of children under 5, and the other calls for a reduction in maternal deaths by three-quarters. Both of these goals are targeted to be met by 2015.

But with current structures and at current funding levels, the world is unlikely to meet these laudable goals. Certainly, the U.S. can't meet these global needs alone. Addressing this critical issue can't be a unilateral effort—countries around the world must also do their part and come forward with much-needed funding.

But passing the CHILD and Newborn Act of 2006 would send a strong message to the international community that this is a priority issue, and it would encourage them to step up to the plate. Millions of lives could be saved in the process.

On September 14, 2005, President Bush stated that the U.S. is ''committed to the Millennium Development Goals.'' I commend the President for his words. But now, it is time for Congress to stand up and make sure that the U.S. fulfills this commitment to protect millions of innocent women and their children around the globe. I urge my colleagues to support this bill.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2765

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Child Health Investment for Long-term Development (CHILD and Newborn) Act of 2006''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) Around the world, approximately 10.8 million children under the age of five die each year, more than 30,000 per day, almost all in the developing world.

(2) Each year in the developing world, four million newborns die in their first four weeks of life.

(3) Sub-Saharan Africa, with only 10 percent of the world's population, accounts for 43 percent of all deaths among children under the age of five.

(4) Countries such as Afghanistan, Angola and Niger experience extreme levels of child mortality, with 25 percent of children dying before their fifth birthday.

(5) For children under the age of five in the developing world, preventable or treatable diseases, such as measles, tetanus, diarrhea, pneumonia, and malaria, are the most common causes of death.

(6) Throughout the developing world, the lack of basic health services, clean water, adequate sanitation, and proper nutrition contribute significantly to child mortality.

(7) Hunger and malnutrition contribute to over five million child deaths annually.

(8) The lack of low-cost antibiotics and anti-malarial drugs contribute to three million child deaths each year.

(9) Lack of access to health services results in 30 million children under the age of one year going without necessary immunizations.

(10) Every year an estimated 250,000 to 500,000 vitamin A-deficient children become blind, with one-half of such children dying within 12 months of losing their sight.

(11) Iron deficiency, affecting over 30 percent of the world's population, causes premature birth, low birth weight, and infections, elevating the risk of death in children.

(12) Two-thirds of deaths of children under five years of age, or 7.1 million children, including three million newborn deaths, could be prevented by low-cost, low-tech health and nutritional interventions.

(13) Exclusive breastfeeding—giving only breast milk for the first six months of life—could prevent an estimated 1.3 million newborn and infant deaths each year, primarily by protecting against diarrhea and pneumonia.

(14) An additional two million lives could be saved annually by providing oral-rehydration therapy prepared with clean water.

(15) During the 1990s, successful immunization programs reduced polio by 99 percent, tetanus deaths by 50 percent, and measles cases by 40 percent.

(16) Between 1998 and 2000, distribution of low-cost vitamin A supplements saved an estimated one million lives.

(17) Expansion of clinical care of newborns and mothers, such as clean delivery by skilled attendants, emergency obstetric care, and neonatal resuscitation, can avert 50 percent of newborn deaths.

(18) Keeping mothers healthy is essential for child survival because illness, complications, or maternal death during or following pregnancy increases the risk for death in newborns and infants.

(19) Each year more than 525,000 women die from causes related to pregnancy and childbirth, with 99 percent of these deaths occurring in developing countries.

(20) The lifetime risk of an African woman dying from a complication related to pregnancy or childbirth is 1 in 16, while the same risk for a woman in a developed country is 1 in 2,800.

(21) Risk factors for maternal death in developing countries include early pregnancy and childbirth, closely spaced births, infectious diseases, malnutrition, and complications during childbirth.

(22) Birth spacing, access to preventive care, skilled birth attendants, and emergency obstetric care can help reduce maternal mortality.

(23) The role of the United States in promoting child survival and maternal health over the past three decades has resulted in millions of lives being saved around the world.

(24) In 2000, the United States joined 188 other countries in supporting eight Millennium Development Goals designed to achieve ''a more peaceful, prosperous and just world''.

(25) Two of the Millennium Development Goals call for a reduction in the mortality rate of children under the age of five by two-thirds and a reduction in maternal deaths by three-quarters by 2015.

(26) On September 14, 2005, President George W. Bush stated before the leaders of the world: ''To spread a vision of hope, the United States is determined to help nations that are struggling with poverty. We are committed to the Millennium Development Goals.''.

(b) PURPOSES.—The purposes of this Act are to—

(1) authorize assistance to improve the health of newborns, children, and mothers in developing countries, including by strengthening the capacity of health systems and health workers;

(2) develop and implement a strategy to improve the health of newborns, children, and mothers, including reducing child and maternal mortality, in developing countries;

(3) to establish a task force to assess, monitor, and evaluate the progress and contributions of relevant departments and agencies of the Government of the United States in achieving the United Nations Millennium Development Goals by 2015 for reducing the mortality of children under the age of five by two-thirds and reducing maternal mortality by three-quarters in developing countries.

SEC. 3. ASSISTANCE TO IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS IN DEVELOPING COUNTRIES.

(a) IN GENERAL.—Chapter 1 of part I of the Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amended—

(1) in section 104(c)—

(A) by striking paragraphs (2) and (3); and

(B) by redesignating paragraph (4) as paragraph (2);

(2) by redesignating sections 104A, 104B, and 104C as sections 104B, 104C, and 104D, respectively; and

(3) by inserting after section 104 the following new section:

''SEC. 104A. ASSISTANCE TO IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS.

''(a) AUTHORIZATION.—Consistent with section 104(c), the President is authorized to furnish assistance, on such terms and conditions as the President may determine, to improve the health of newborns, children, and mothers in developing countries.

''(b) ACTIVITIES SUPPORTED.—Assistance provided under subsection (b) shall, to the maximum extent practicable, be used to carry out the following activities:

''(1) Activities to strengthen the capacity of health systems in developing countries, including training for clinicians, nurses, technicians, sanitation and public health workers, community-based health workers, midwives and birth attendants, peer educators, and private sector enterprises.

''(2) Activities to provide health care access to underserved and marginalized populations.

''(3) Activities to ensure the supply, logistical support, and distribution of essential drugs, vaccines, commodities, and equipment to regional, district, and local levels.

''(4) Activities to educate underserved and marginalized populations to seek health care when appropriate, including clinical and community-based activities.

''(5) Activities to integrate and coordinate assistance provided under this section with existing health programs for—

''(A) the prevention of the transmission of HIV from mother-to-child and other HIV/AIDS counseling, care, and treatment activities;

''(B) malaria;

''(C) tuberculosis; and

''(D) child spacing.

''(6) Activities to expand access to safe water and sanitation.

''(7) Activities to expand the use of and technical support for appropriate technology to reduce acute respiratory infection from firewood smoke inhalation.

''(c) GUIDELINES.—To the maximum extent practicable, programs, projects, and activities carried out using assistance provided under this section shall be—

''(1) carried out through private and voluntary organizations, as well as faith-based organizations, giving priority to organizations that demonstrate effectiveness and commitment to improving the health of newborns, children, and mothers;

''(2) carried out with input by host countries, including civil society and local communities, as well as other donors and multilateral organizations;

''(3) carried out with input by beneficiaries and other directly affected populations, especially women and marginalized communities; and

''(4) designed to build the capacity of host country governments and civil society organizations.

''(d) ANNUAL REPORT.—Not later than January 31 of each year, the President shall transmit to Congress a report on the implementation of this section for the prior fiscal year.

''(e) DEFINITIONS.—In this section:

''(1) AIDS.—The term 'AIDS' has the meaning given the term in section 104B(g)(1) of this Act.

''(2) HIV.—The term 'HIV' has the meaning given the term in section 104B(g)(2) of this Act.

''(3) HIV/AIDS.—The term 'HIV/AIDS' has the meaning given the term in section 104B(g)(3) of this Act.''.

(b) CONFORMING AMENDMENTS.—The Foreign Assistance Act of 1961 (22 U.S.C. 2151 et seq.) is amended—

(1) in section 104(c)(2) (as redesignated by subsection (a)(1)(B) of this section), by striking ''and 104C'' and inserting ''104C, and 104D'';

(2) in section 104B (as redesignated by subsection (a)(2) of this section)—

(A) in subsection (c)(1), by inserting ''and section 104A'' after ''section 104(c)'';

(B) in subsection (e)(2), by striking ''section 104B, and section 104C'' and inserting ''section 104C, and section 104D''; and

(C) in subsection (f), by striking ''section 104(c), this section, section 104B, and section 104C'' and inserting ''section 104(c), section 104A, this section, section 104C, and section 104D'';

(3) in subsection (c) of section 104C (as redesignated by subsection (a)(2) of this section), by inserting ''and section 104A'' after ''section 104(c)'';

(4) in subsection (c) of section 104D (as redesignated by subsection (a)(2) of this section), by inserting ''and section 104A'' after ''section 104(c)''; and

(5) in the first sentence of section 119(c), by striking ''section 104(c)(2), relating to Child Survival Fund'' and inserting ''section 104A''.

SEC. 4. DEVELOPMENT OF STRATEGY TO IMPROVE THE HEALTH OF NEWBORNS, CHILDREN, AND MOTHERS IN DEVELOPING COUNTRIES.

(a) DEVELOPMENT OF STRATEGY.—The President shall develop a comprehensive strategy to improve the health of newborns, children, and mothers, including reducing newborn, child, and maternal mortality, in developing countries.

(b) COMPONENTS.—The strategy developed pursuant to subsection (a) shall include the following:

(1) Programmatic areas and interventions providing maximum health benefits to populations at risk as well as maximum reduction in mortality, including—

(A) costs and benefits of programs and interventions; and

(B) investments needed in identified programs and interventions to achieve the greatest results.

(2) An identification of countries with priority needs for the five-year period beginning on the date of the enactment of this Act based on—

(A) the neonatal mortality rate;

(B) the mortality rate of children under the age of five;

(C) the maternal mortality rate;

(D) the percentage of women and children with limited or no access to basic health care; and

(E) additional criteria for evaluation such as—

(i) the percentage of one-year old children who are fully immunized;

(ii) the percentage of children under the age of five who sleep under insecticide-treated bed nets;

(iii) the percentage of children under the age of five with fever treated with anti-malarial drugs;

(iv) the percentage of children under the age of five who are covered by vitamin A supplementation;

(v) the percentage of children under the age of five with diarrhea who are receiving oral-rehydration therapy and continued feeding;

(vi) the percentage of children under the age of five with pneumonia who are receiving appropriate care;

(vii) the percentage of the population with access to improved sanitation facilities;

(viii) the percentage of the population with access to safe drinking water;

(ix) the percentage of children under the age of five who are underweight for their age;

(x) the percentage of births attended by skilled health care personnel;

(xi) the percentage of women with access to emergency obstetric care;

(xii) the potential for implementing newborn, child, and maternal health interventions at scale; and

(xiii) the demonstrated commitment of countries to newborn, child, and maternal health.

(3) A description of how United States assistance complements and leverages efforts by other donors, as well as builds capacity and self-sufficiency among recipient countries.

(4) An expansion of the Child Survival and Health Grants Program of the United States Agency for International Development to provide additional support programs and interventions determined to be efficacious and cost-effective in improving health and reducing mortality.

(5) Enhanced coordination among relevant departments and agencies of the Government of the United States engaged in activities to improve the health of newborns, children, and mothers in developing countries.

(c) REPORT.—Not later than 180 days after the date of the enactment of this Act, the President shall transmit to Congress a report that contains the strategy described in this section.

SEC. 5. INTERAGENCY TASK FORCE ON CHILD SURVIVAL AND MATERNAL HEALTH IN DEVELOPING COUNTRIES.

(a) ESTABLISHMENT.—There is established a task force to be known as the Interagency Task Force on Child Survival and Maternal Health in Developing Countries (in this section referred to as the ''Task Force'').

(b) DUTIES.—

(1) IN GENERAL.—The Task Force shall assess, monitor, and evaluate the progress and contributions of relevant departments and agencies of the Government of the United States in achieving the Millennium Development Goals by 2015 for reducing the mortality of children under the age of five by two-thirds and reducing maternal mortality by three-quarters in developing countries, including by—

(A) identifying and evaluating programs and interventions that directly or indirectly contribute to the reduction of child and maternal mortality rates;

(B) assessing effectiveness of programs, interventions, and strategies toward achieving the maximum reduction of child and maternal mortality rates;

(C) assessing the level of coordination among relevant departments and agencies of the Government of the United States, the international community, international organizations, faith-based organizations, academic institutions, and the private sector;

(D) assessing the contributions made by United States-funded programs toward achieving the Millennium Development Goals;

(E) identifying the bilateral efforts of other nations and multilateral efforts toward achieving the Millennium Development Goals; and

(F) preparing the annual report required by subsection (f).

(2) CONSULTATION.—To the maximum extent practicable, the Task Force shall consult with individuals with expertise in the matters to be considered by the Task Force who are not officers or employees of the Government of the United States, including representatives of United States-based nongovernmental organizations (including faith-based organizations and private foundations), academic institutions, private corporations, the United Nations Children's Fund (UNICEF), and the World Bank.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Task Force shall be composed of the following members:

(A) The Administrator of the United States Agency for International Development.

(B) The Assistant Secretary of State for Population, Refugees and Migration.

(C) The Coordinator of United States Government Activities to Combat HIV/AIDS Globally.

(D) The Director of the Office of Global Health Affairs of the Department of Health and Human Services.

(E) The Under Secretary for Food, Nutrition and Consumer Services of the Department of Agriculture.

(F) The Chief Executive Officer of the Millennium Challenge Corporation.

(G) The Director of the Peace Corps.

(H) Other officials of relevant departments and agencies of the Federal Government who shall be appointed by the President.

(2) CHAIRPERSON.—The Administrator of the United States Agency for International Development shall serve as chairperson of the Task Force.

(d) MEETINGS.—The Task Force shall meet on a regular basis, not less often than quarterly, on a schedule to be agreed upon by the members of the Task Force, and starting not later than 90 days after the date of the enactment of this Act.

(e) DEFINITION.—In this subsection, the term ''Millennium Development Goals'' means the key development objectives described in the United Nations Millennium Declaration, as contained in United Nations General Assembly Resolution 55/2 (September 2000).

(f) REPORT.—Not later than 120 days after the date of the enactment of this Act, and not later than April 30 of each year thereafter, the Task Force shall submit to Congress and the President a report on the implementation of this section.

SEC. 6. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out this Act, and the amendments made by this Act, $660,000,000 for fiscal year 2007 and $1,200,000,000 for each of the fiscal years 2008 through 2011.

(b) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to the authorization of appropriations under subsection (a) are authorized to remain available until expended.

By Mr. VOINOVICH (for himself, Mr. BINGAMAN, Mr. DEWINE, and Mr. AKAKA):

S. 2772. A bill to provide for innovation in health care through State initiatives that expand coverage and access and improve quality and efficiency in the health care system; to the Committee on Health, Education, Labor, and Pensions.

Mr. VOINOVICH. Mr. President, I rise to speak about a bill my colleague Senator BINGAMAN and I introduced today, the Health Care Partnership Act. For too many years, I have listened to my colleagues on both sides of the aisle talk about the rising cost of health care and the growing number of uninsured Americans. Yet, we have not been able to make much progress here at the Federal level to find a meaningful solution for the dilemma this Nation is facing regarding access to quality, affordable health care. Next to the economy, it is the greatest domestic challenge facing our Nation. In fact, the rising cost of health care is a major part of what is hurting our competitiveness in the global marketplace.

While surveys have indicated that health insurance premiums have stabilized—a 9.2 percent increase in 2006 and 2005 and compared with a 12.3 percent in 2004; 14.7 percent in 2003; and 15.2 percent in 2002—health insurance costs continue to be a significant factor impacting American competitiveness. In addition, the share of costs that individuals have paid for employer sponsored insurance has risen roughly 2 percent each year, from 31.4 percent of health care costs in 2001 to 38.4 percent this year.

In fact, spending on health care in the United States reached $1.9 trillion in 2004—almost 16.5 percent of our GDP—the largest share ever.

Yet, despite all the increases in health care spending some 46 million Americans—15 percent of the population—had no health insurance at some point last year. This number has increased steadily. In 2000, that number was 39.8 million. In 2002 it was 43.6 million.

These statistics are startling and it is time that we do something about them. The bill Senator BINGAMAN and I are introducing today aims to break the log-jam here in Washington and

allow states the freedom to explore with health care reform options. This bill would support state-based efforts to reduce the uninsured and the cost of health care, improve quality, improve access to care, and expand information technology.

I have been in this situation before. As Governor of Ohio, I had to work creatively to expand coverage and deal with increasing health care costs for a growing number of uninsured Ohioans. I am happy to report that we were able to make some progress toward reducing the number of uninsured Ohioans during my time as the head of the state by negotiating with the state unions to move to managed care; by controlling Medicaid costs to the point where from 1995 to 1998, due to good stewardship and management, Ohio ended up underspending on Medicaid without harming families; and implementing the S-CHIP program to provide coverage for uninsured children.

Like we did in Ohio, a number of states are already actively pursuing efforts to reduce the number of their residents who lack adequate health care coverage. The Health Care Partnership Act will build on what states like Massachusetts and others are doing, while providing a mechanism to analyze results and make recommendations for future action at the Federal level.

Under the Health Partnership Act, Congress would authorize grants to individual states, groups of states, and Indian tribes and local governments to carry out any of a broad range of strategies to improve our Nation's health care delivery. The bill creates a mechanism for states to apply for grants to a bipartisan ''State Health Innovation Commission'' housed at the Department of Health and Human Services (HHS). After reviewing the state proposals, the Commission would submit to Congress a list of recommended state applications. The Commission would also recommend the amount of Federal grant money each state should receive to carry out the actions described in their plan.

Most importantly, at the end of the five-year period, the Commission would be required to report to Congress whether the states are meeting the goals of the Act. The Commission would then recommend future action Congress should take concerning overall reform, including whether or not to extend the state program.

I believe it is important that we pass this legislation to provide a platform from which we can have a thoughtful conversation about health care reform here in Washington. Since I have been in the Senate, Congress has made some progress toward improving health care, most notably for our 43 million seniors who now have access to affordable prescription medication through the Medicare Modernization Act. We have also increased funding for community health centers and safety net hospitals that provide health care for the uninsured and under insured; increased the use of technology in our health care delivery system; and improved the safety of medical care by passing a medical errors reporting bill.

Yet, these incremental steps are not enough, and we have been at this too long here in Washington without comprehensive, meaningful results. I ask for my colleagues' support for this bipartisan bill that I hope will move us closer toward a solution to the uninsured.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2772

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Partnership Act''.

SEC. 2. STATE HEALTH REFORM PROJECTS.

(a) PURPOSE; ESTABLISHMENT OF STATE HEALTH CARE EXPANSION AND IMPROVEMENT PROGRAM.—The purposes of the programs approved under this section shall include, but not be limited to—

(1) achieving the goals of increased health coverage and access;

(2) ensuring that patients receive high-quality, appropriate health care;

(3) improving the efficiency of health care spending; and

(4) testing alternative reforms, such as building on the public or private health systems, or creating new systems, to achieve the objectives of this Act.

(b) APPLICATIONS BY STATES, LOCAL GOVERNMENTS, AND TRIBES.—

(1) ENTITIES THAT MAY APPLY.—

(A) IN GENERAL.—A State, in consultation with local governments, Indian tribes, and Indian organizations involved in the provision of health care, may apply for a State health care expansion and improvement program for the entire State (or for regions of the State) under paragraph (2).

(B) REGIONAL GROUPS.—A regional entity consisting of more than one State may apply for a multi State health care expansion and improvement program for the entire region involved under paragraph (2).

(C) DEFINITION.—In this Act, the term ''State'' means the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico. Such term shall include a regional entity described in subparagraph (B).

(2) SUBMISSION OF APPLICATION.—In accordance with this section, each State desiring to implement a State health care expansion and improvement program may submit an application to the State Health Innovation Commission under subsection (c) (referred to in this section as the ''Commission'') for approval.

(3) LOCAL GOVERNMENT APPLICATIONS.—

(A) IN GENERAL.—Where a State declines to submit an application under this section, a unit of local government of such State, or a consortium of such units of local governments, may submit an application directly to the Commission for programs or projects under this subsection. Such an application shall be subject to the requirements of this section.

(B) OTHER APPLICATIONS.—Subject to such additional guidelines as the Secretary may prescribe, a unit of local government, Indian tribe, or Indian health organization may submit an application under this section, whether or not the State submits such an application, if such unit of local government can demonstrate unique demographic needs or a significant population size that warrants a substate program under this subsection.

(c) STATE HEALTH INNOVATION COMMISSION.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary shall establish a State Health Innovation Commission that shall—

(A) be comprised of—

(i) the Secretary;

(ii) four State governors to be appointed by the National Governors Association on a bipartisan basis;

(iii) two members of a State legislature to be appointed by the National Conference of State Legislators on a bipartisan basis;

(iv) two county officials to be appointed by the National Association of Counties on a bipartisan basis;

(v) two mayors to be appointed by the United States Conference of Mayors on a bipartisan basis;

(vi) two individuals to be appointed by the Speaker of the House of Representatives;

(vii) two individuals to be appointed by the Minority Leader of the House of Representatives;

(viii) two individuals to be appointed by the Majority Leader of the Senate;

(ix) two individuals to be appointed by the Minority Leader of the Senate; and

(x) two individuals who are members of federally-recognized Indian tribes to be appointed on a bipartisan basis by the National Congress of American Indians;

(B) upon approval of ⅔ of the members of the Commission, provide the States with a variety of reform options for their applications, such as tax credit approaches, expansions of public programs such as medicaid and the State Children's Health Insurance Program, the creation of purchasing pooling arrangements similar to the Federal Employees Health Benefits Program, individual market purchasing options, single risk pool or single payer systems, health savings accounts, a combination of the options described in this clause, or other alternatives determined appropriate by the Commission, including options suggested by States, Indian tribes, or the public;

(C) establish, in collaboration with a qualified and independent organization such as the Institute of Medicine, minimum performance measures and goals with respect to coverage, quality, and cost of State programs, as described under subsection (d)(1);

(D) conduct a thorough review of the grant application from a State and carry on a dialogue with all State applicants concerning possible modifications and adjustments;

(E) submit the recommendations and legislative proposal described in subsection (d)(4)(B);

(F) be responsible for monitoring the status and progress achieved under program or projects granted under this section;

(G) report to the public concerning progress made by States with respect to the performance measures and goals established under this Act, the periodic progress of the State relative to its State performance measures and goals, and the State program application procedures, by region and State jurisdiction;

(H) promote information exchange between States and the Federal Government; and

(I) be responsible for making recommendations to the Secretary and the Congress, using equivalency or minimum standards, for minimizing the negative effect of State program on national employer groups, provider organizations, and insurers because of

differing State requirements under the programs.

(2) PERIOD OF APPOINTMENT; REPRESENTATION REQUIREMENTS; VACANCIES.—Members shall be appointed for a term of 5 years. In appointing such members under paragraph (1)(A), the designated appointing individuals shall ensure the representation of urban and rural areas and an appropriate geographic distribution of such members. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(3) CHAIRPERSON, MEETINGS.—

(A) CHAIRPERSON.—The Commission shall select a Chairperson from among its members.

(B) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(C) MEETINGS.—Not later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting. The Commission shall meet at the call of the Chairperson.

(4) POWERS OF THE COMMISSION.—

(A) NEGOTIATIONS WITH STATES.—The Commission may conduct detailed discussions and negotiations with States submitting applications under this section, either individually or in groups, to facilitate a final set of recommendations for purposes of subsection (d)(4)(B). Such negotiations shall include consultations with Indian tribes, and be conducted in a public forum.

(B) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this subsection.

(C) MEETINGS.—In addition to other meetings the Commission may hold, the Commission shall hold an annual meeting with the participating States under this section for the purpose of having States report progress toward the purposes in subsection (a)(1) and for an exchange of information.

(D) INFORMATION.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this subsection. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission if the head of the department or agency involved determines it appropriate.

(E) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(5) PERSONNEL MATTERS.—

(A) COMPENSATION.—Each member of the Commission who is not an officer or employee of the Federal Government or of a State or local government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(B) TRAVEL EXPENSES.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(C) STAFF.—The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(D) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(E) TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(6) FUNDING.—For the purpose of carrying out this subsection, there are authorized to be appropriated $3,000,000 for fiscal year 2006 and each fiscal year thereafter.

(d) REQUIREMENTS FOR PROGRAMS.—

(1) STATE PLAN.—A State that seeks to receive a grant under subsection (f) to operate a program under this section shall prepare and submit to the Commission, as part of the application under subsection (b), a State health care plan that shall have as its goal improvements in coverage, quality and costs. To achieve such goal, the State plan shall comply with the following:

(A) COVERAGE.—With respect to coverage, the State plan shall—

(i) provide and describe the manner in which the State will ensure that an increased number of individuals residing within the State will have expanded access to health care coverage with a specific 5-year target for reduction in the number of uninsured individuals through either private or public program expansion, or both, in accordance with the options established by the Commission;

(ii) describe the number and percentage of current uninsured individuals who will achieve coverage under the State health program;

(iii) describe the minimum benefits package that will be provided to all classes of beneficiaries under the State health program;

(iv) identify Federal, State, or local and private programs that currently provide health care services in the State and describe how such programs could be coordinated with the State health program, to the extent practicable; and

(v) provide for improvements in the availability of appropriate health care services that will increase access to care in urban, rural, and frontier areas of the State with medically underserved populations or where there is an inadequate supply of health care providers.

(B) QUALITY.—With respect to quality, the State plan shall—

(i) provide a plan to improve health care quality in the State, including increasing effectiveness, efficiency, timeliness, patient focused, equity while reducing health disparities, and medical errors; and

(ii) contain appropriate results-based quality indicators established by the Commission that will be addressed by the State as well as State-specific quality indicators.

(C) COSTS.—With respect to costs, the State plan shall—

(i) provide that the State will develop and implement systems to improve the efficiency of health care, including a specific 5-year target for reducing administrative costs (including paperwork burdens);

(ii) describe the public and private sector financing to be provided for the State health program;

(iii) estimate the amount of Federal, State, and local expenditures, as well as, the costs to business and individuals under the State health program;

(iv) describe how the State plan will ensure the financial solvency of the State health program; and

(v) provide that the State will prepare and submit to the Secretary and the Commission such reports as the Secretary or Commission may require to carry out program evaluations.

(D) HEALTH INFORMATION TECHNOLOGY.—With respect to health information technology, the State plan shall provide methodology for the appropriate use of health information technology to improve infrastructure, such as improving the availability of evidence-based medical and outcomes data to providers and patients, as well as other health information (such as electronic health records, electronic billing, and electronic prescribing).

(2) TECHNICAL ASSISTANCE.—The Secretary shall, if requested, provide technical assistance to States to assist such States in developing applications and plans under this section, including technical assistance by private sector entities if determined appropriate by the Commission.

(3) INITIAL REVIEW.—With respect to a State application for a grant under subsection (b), the Secretary and the Commission shall complete an initial review of such State application within 60 days of the receipt of such application, analyze the scope of the proposal, and determine whether additional information is needed from the State. The Commission shall advise the State within such period of the need to submit additional information.

(4) FINAL DETERMINATION.—

(A) IN GENERAL.—Not later than 90 days after completion of the initial review under paragraph (3), the Commission shall determine whether to submit a State proposal to Congress for approval.

(B) VOTING.—

(i) IN GENERAL.—The determination to submit a State proposal to Congress under subparagraph (A) shall be approved by ⅔ of the members of the Commission who are eligible to participate in such determination subject to clause (ii).

(ii) ELIGIBILITY.—A member of the Commission shall not participate in a determination under subparagraph (A) if—

(I) in the case of a member who is a Governor, such determination relates to the State of which the member is the Governor; or

(II) in the case of member not described in subclause (I), such determination relates to the geographic area of a State of which such member serves as a State or local official.

(C) SUBMISSION.—Not later than 90 days prior to October 1 of each fiscal year, the Commission shall submit to Congress a list, in the form of a legislative proposal, of the State applications that the Commission recommends for approval under this section.

(D) APPROVAL.—With respect to a fiscal year, a State proposal that has been recommended under subparagraph (B) shall be deemed to be approved, and subject to the availability of appropriations, Federal funds shall be provided to such program, unless a joint resolution has been enacted disapproving such proposal as provided for in

subsection (e). Nothing in the preceding sentence shall be construed to include the approval of State proposals that involve waivers or modifications in applicable Federal law.

(5) PROGRAM OR PROJECT PERIOD.—A State program or project may be approved for a period of 5 years and may be extended for subsequent 5-year periods upon approval by the Commission and the Secretary, based upon achievement of targets, except that a shorter period may be requested by a State and granted by the Secretary.

(e) EXPEDITED CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION AND COMMITTEE CONSIDERATION.—

(A) INTRODUCTION.—The legislative proposal submitted pursuant to subsection (d)(4)(B) shall be in the form of a joint resolution (in this subsection referred to as the ''resolution''). Such resolution shall be introduced in the House of Representatives by the Speaker, and in the Senate, by the Majority Leader, immediately upon receipt of the language and shall be referred to the appropriate committee of Congress. If the resolution is not introduced in accordance with the preceding sentence, the resolution may be introduced in either House of Congress by any member thereof.

(B) COMMITTEE CONSIDERATION.—A resolution introduced in the House of Representatives shall be referred to the Committee on Ways and Means of the House of Representatives. A resolution introduced in the Senate shall be referred to the Committee on Finance of the Senate. Not later than 15 calendar days after the introduction of the resolution, the committee of Congress to which the resolution was referred shall report the resolution or a committee amendment thereto. If the committee has not reported such resolution (or an identical resolution) at the end of 15 calendar days after its introduction or at the end of the first day after there has been reported to the House involved a resolution, whichever is earlier, such committee shall be deemed to be discharged from further consideration of such reform bill and such reform bill shall be placed on the appropriate calendar of the House involved.

(2) EXPEDITED PROCEDURE.—

(A) CONSIDERATION.—Not later than 5 days after the date on which a committee has been discharged from consideration of a resolution, the Speaker of the House of Representatives, or the Speaker's designee, or the Majority Leader of the Senate, or the Leader's designee, shall move to proceed to the consideration of the committee amendment to the resolution, and if there is no such amendment, to the resolution. It shall also be in order for any member of the House of Representatives or the Senate, respectively, to move to proceed to the consideration of the resolution at any time after the conclusion of such 5-day period. All points of order against the resolution (and against consideration of the resolution) are waived. A motion to proceed to the consideration of the resolution is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the resolution, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the House of Representatives or the Senate, as the case may be, shall immediately proceed to consideration of the resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the House of Representatives or the Senate, as the case may be, until disposed of.

(B) CONSIDERATION BY OTHER HOUSE.—If, before the passage by one House of the resolution that was introduced in such House, such House receives from the other House a resolution as passed by such other House—

(i) the resolution of the other House shall not be referred to a committee and may only be considered for final passage in the House that receives it under clause (iii);

(ii) the procedure in the House in receipt of the resolution of the other House, with respect to the resolution that was introduced in the House in receipt of the resolution of the other House, shall be the same as if no resolution had been received from the other House; and

(iii) notwithstanding clause (ii), the vote on final passage shall be on the reform bill of the other House.

Upon disposition of a resolution that is received by one House from the other House, it shall no longer be in order to consider the resolution bill that was introduced in the receiving House.

(C) CONSIDERATION IN CONFERENCE.—Immediately upon a final passage of the resolution that results in a disagreement between the two Houses of Congress with respect to the resolution, conferees shall be appointed and a conference convened. Not later than 10 days after the date on which conferees are appointed, the conferees shall file a report with the House of Representatives and the Senate resolving the differences between the Houses on the resolution. Notwithstanding any other rule of the House of Representatives or the Senate, it shall be in order to immediately consider a report of a committee of conference on the resolution filed in accordance with this subclause. Debate in the House of Representatives and the Senate on the conference report shall be limited to 10 hours, equally divided and controlled by the Speaker of the House of Representatives and the Minority Leader of the House of Representatives or their designees and the Majority and Minority Leaders of the Senate or their designees. A vote on final passage of the conference report shall occur immediately at the conclusion or yielding back of all time for debate on the conference report.

(3) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(4) LIMITATION.—The amount of Federal funds provided with respect to any State proposal that is deemed approved under subsection (d)(3) shall not exceed the cost provided for such proposals within the concurrent resolution on the budget as enacted by Congress for the fiscal year involved.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide a grant to a State that has an application approved under subsection (b) to enable such State to carry out an innovative State health program in the State.

(2) AMOUNT OF GRANT.—The amount of a grant provided to a State under paragraph (1) shall be determined based upon the recommendations of the Commission, subject to the amount appropriated under subsection (k).

(3) PERFORMANCE-BASED FUNDING ALLOCATION AND PRIORITIZATION.—In awarding grants under paragraph (1), the Secretary shall—

(A) fund a diversity of approaches as provided for by the Commission in subsection (c)(1)(B);

(B) give priority to those State programs that the Commission determines have the greatest opportunity to succeed in providing expanded health insurance coverage and in providing children, youth, and other vulnerable populations with improved access to health care items and services; and

(C) link allocations to the State to the meeting of the goals and performance measures relating to health care coverage, quality, and health care costs established under this Act through the State project application process.

(4) MAINTENANCE OF EFFORT.—A State, in utilizing the proceeds of a grant received under paragraph (1), shall maintain the expenditures of the State for health care coverage purposes for the support of direct health care delivery at a level equal to not less than the level of such expenditures maintained by the State for the fiscal year preceding the fiscal year for which the grant is received.

(5) REPORT.—At the end of the 5-year period beginning on the date on which the Secretary awards the first grant under paragraph (1), the State Health Innovation Advisory Commission established under subsection (c) shall prepare and submit to the appropriate committees of Congress, a report on the progress made by States receiving grants under paragraph (1) in meeting the goals of expanded coverage, improved quality, and cost containment through performance measures established during the 5-year period of the grant. Such report shall contain the recommendation of the Commission concerning any future action that Congress should take concerning health care reform, including whether or not to extend the program established under this subsection.

(g) MONITORING AND EVALUATION.—

(1) ANNUAL REPORTS AND PARTICIPATION BY STATES.—Each State that has received a program approval shall—

(A) submit to the Commission an annual report based on the period representing the respective State's fiscal year, detailing compliance with the requirements established by the Commission and the Secretary in the approval and in this section; and

(B) participate in the annual meeting under subsection (c)(4)(B).

(2) EVALUATIONS BY COMMISSION.—The Commission, in consultation with a qualified and independent organization such as the Institute of Medicine, shall prepare and submit to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce, the Committee on Education and the Workforce, and the Committee on Ways and Means of the House of Representatives annual reports that shall contain—

(A) a description of the effects of the reforms undertaken in States receiving approvals under this section;

(B) a description of the recommendations of the Commission and actions taken based on these recommendations;

(C) an evaluation of the effectiveness of such reforms in—

(i) expanding health care coverage for State residents;

(ii) improving the quality of health care provided in the States; and

(iii) reducing or containing health care costs in the States;

(D) recommendations regarding the advisability of increasing Federal financial assistance for State ongoing or future health program initiatives, including the amount and source of such assistance; and

(E) as required by the Commission or the Secretary under subsection (f)(5), a periodic, independent evaluation of the program.

(h) NONCOMPLIANCE.—

(1) CORRECTIVE ACTION PLANS.—If a State is not in compliance with a requirements of this section, the Secretary shall develop a corrective action plan for such State.

(2) TERMINATION.—For good cause and in consultation with the Commission, the Secretary may revoke any program granted under this section. Such decisions shall be subject to a petition for reconsideration and appeal pursuant to regulations established by the Secretary.

(i) RELATIONSHIP TO FEDERAL PROGRAMS.—

(1) IN GENERAL.—Nothing in this Act, or in section 1115 of the Social Security Act (42 U.S.C. 1315) shall be construed as authorizing the Secretary, the Commission, a State, or any other person or entity to alter or affect in any way the provisions of title XIX of such Act (42 U.S.C. 1396 et seq.) or the regulations implementing such title.

(2) MAINTENANCE OF EFFORT.—No payment may be made under this section if the State adopts criteria for benefits, income, and resource standards and methodologies for purposes of determining an individual's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of the date of enactment of this Act.

(j) MISCELLANEOUS PROVISIONS.—

(1) APPLICATION OF CERTAIN REQUIREMENTS.—

(A) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

(i) IN GENERAL.—Subject to subparagraph (B), a State shall not permit the imposition of any preexisting condition exclusion for covered benefits under a program or project under this section.

(ii) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State program or project provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the program or project may permit the imposition of a preexisting condition exclusion but only insofar and to the extent that such exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

(B) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under the program or project shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

(2) PREVENTION OF DUPLICATIVE PAYMENTS.—

(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for health assistance provided for an individual to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided health assistance under the plan.

(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as provided in any other provision of law, no payment shall be made to a State under this section for expenditures for health assistance provided for an individual to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) of the Social Security Act shall apply.

(3) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of the Social Security Act shall apply to States under this section in the same manner as they apply to a State under such title XIX:

(A) TITLE XIX PROVISIONS.—

(i) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(ii) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(iii) Section 1903(w) (relating to limitations on provider taxes and donations).

(iv) Section 1920A (relating to presumptive eligibility for children).

(B) TITLE XI PROVISIONS.—

(i) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

(ii) Section 1124 (relating to disclosure of ownership and related information).

(iii) Section 1126 (relating to disclosure of information about certain convicted individuals).

(iv) Section 1128A (relating to civil monetary penalties).

(v) Section 1128B(d) (relating to criminal penalties for certain additional charges).

(vi) Section 1132 (relating to periods within which claims must be filed).

(4) RELATION TO OTHER LAWS.—

(A) HIPAA.—Health benefits coverage provided under a State program or project under this section shall be treated as creditable coverage for purposes of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(B) ERISA.—Nothing in this section shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1))).

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary in each fiscal year. Amounts appropriated for a fiscal year under this subsection and not expended may be used in subsequent fiscal years to carry out this section.

Mr. BINGAMAN. I am pleased to announce today the introduction of bipartisan legislation with Senator VOINOVICH entitled the ''Health Partnership Act of 2006'' with additional bipartisan support from Senators DEWINE and AKAKA. The ''Health Partnership Act'' is intended to move beyond the political gridlock in Washington, D.C., and set us on a path toward finding solutions to affordable, quality health care for all Americans by creating partnerships between the federal government, state and local governments, private payers, and health care providers to implement different and promising approaches to health care.

Federal funding and support would be committed to states to reduce the number of uninsured, reduce costs, and improve the quality of health care for all Americans. Should a state decline to apply or if a unique need exists, local governments also would be authorized to apply for a federal grant for such purposes.

States, local governments, and tribes and tribal governments would be able to submit applications to the federal government for funding to implement a state health care expansion and improvement program to a bipartisan ''State Health Innovation Commission.'' Based on funding available through the federal budget process, the Commission would approve a variety of reform options and innovative approaches.

This federalist approach to health reform would encourage a broad array of reform options that would be closely monitored to see what is working and what is not. As Supreme Court Justice Louis D. Brandeis wrote in 1932, ''It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.''

Our bipartisan legislation, the ''Health Partnership Act,'' encourages this type of state-based innovation and will help the nation better address both the policy and the politics of health care reform. We do not have consensus at the federal level on anyone approach and so encouraging states to adopt a variety of approaches will help us all better understand what may or may not work. And, it is well past the time when we need action to be taking place to address the growing and related problems of the uninsured and increasing health care costs.

In fact, spending on health care in our country has now reached $2 trillion annually, and yet, the number of uninsured has increased to 46 million people, which is six million more than in 2000. The consequences are staggering, as uninsured citizens get about half the medical care they need compared to those with health insurance and, according to the Institute of Medicine, about 18,000 unnecessary deaths occur each year in the United States because of lack of health Insurance.

While gridlock absent a solution continues to permeate Washington, DC, a number of states and local governments are moving ahead with health reform. The premise on which this bill is based is that the federal government should provide support for such efforts rather than constantly undermining them.

The ''Health Partnership Act'' would provide such support, as it authorizes grants to states, groups of states, local governments, and Indian tribes and organizations to carry out any of a broad range of strategies to reach the goals

of reducing the number of uninsured, reducing costs, and improving the quality of care.

As usual, state and local governments are not waiting around for federal action. This is exactly what was happening in the early 1990s as states such as New Mexico, Massachusetts, Pennsylvania, Florida, Rhode Island, Hawaii, Maryland, Tennessee, Vermont, and Washington led the way to expanding coverage to children through the enactment of a variety of health reforms. Some of these programs worked better than others and the federal government responded in 1997 with passage of the ''State Children's Health Insurance Program'' or SCHIP. This legislation received broad bipartisan support and was built upon the experience of the state expansions. SCHIP continues to be a state-based model that covers millions of children and continues to have broad-based bipartisan support across this nation.

So, why not use that successful model and build upon it? In fact, state and local governments are already taking up that challenge and the federal government should, through the enactment of the ''Health Partnership Act,'' do what it can to be helpful with those efforts. For example—

On November 15, 2005, Illinois Governor Rod Blagojevich signed into law the ''Covering All Kids Health Insurance Act'' which, beginning in July 2006, will attempt to make insurance coverage available to all uninsured children.

In Massachusetts, Governor Mitt Romney recently signed into law legislation that requires all Bay State residents to have health insurance. Virtually everyone interested in solutions to our nation's health care problems are looking at the Massachusetts ''experiment'' as a possible solution.

Other states, including New Mexico, Maine, West Virginia, Oklahoma, and New York have enacted other health reforms that have had mixed success.

All of these efforts are very important to add to our knowledge base, which can then lead to the formation of a possible national solution to our uninsured and affordability crisis. We can learn from each and every one of these efforts, whether successful or failed.

Commonwealth Fund President Karen Davis said it well by noting that state-based reforms, such as that passed in Massachusetts, are very good news. As she notes, ''First, any substantive effort to expand access to coverage is worthwhile, given the growing number of uninsured in this country and the large body of evidence showing the dangerous health implications of lacking coverage.''

She adds, ''But something more important is at work here, While we urgently need a national solution so that all Americans have insurance, it doesn't appear that we'll be getting one at the federal level any time soon. So what Massachusetts has done potentially holds lessons for every state.'' I would add that it holds lessons for the federal government as well and not just for the mechanics of implementing health reform policy but also to the politics of health reform.

As she concludes, ''One particularly cogent lesson is the manner in which the measure was crafted—via a civil process that successfully brought together numerous players from across the political business, health care delivery, and policy sectors.''

Mr. President, Senator VOINOVICH and I have worked together for many months now on this legislation via a process much like that described by Karen Davis. The legislation stems from past legislative efforts by senators such as Bob Graham, Mark Hatfield, and Paul Wellstone, but also from work across ideological lines by Henry Aaron of the Brookings Institute and Stuart Butler of the Heritage Foundation.

The legislation also received much advice and support from Dr. Tim Garson who, as Dean of the University of Virginia, brought a much needed provider perspective which is reflected in support for the legislation from the American Medical Association, the American Academy of Pediatrics, the American College of Physicians, the American College of Cardiology, American Gastroenterological Association, the Visiting Nurses Association, the National Association of Community Health Centers, and from state-based health providers such as the New Mexico Medical Society and Ohio Association of Community Health Centers.

And the legislation also received much comment and support from consumer-based groups advocating for national health reform, including that by Dr. Ken Frisof and UHCAN, which is the Universal Health Care Action Network, Bill Vaughan at Consumers Union, and from numerous health care advocates in New Mexico, including Community Action New Mexico, Health Action New Mexico, Health Care for All Campaign of New Mexico, New Mexico Center on Law and Poverty, New Mexico Health Choices Initiative, New Mexico POZ Coalition, New Mexico Public Health Association, New Mexico Religious Coalition for Reproductive Choice, New Mexico Progressive Alliance for Community Empowerment, and the Health Security for New Mexicans Campaign, which includes 115 organizations based in the State.

Support from all stakeholders in our nation's health care system has been sought and I would like to thank the many organizations from New Mexico for their support and input to this legislation. There is great urgency in New Mexico because our State, like all of those along the U.S.-Mexico border, faces a severe health care crisis. In fact, New Mexico ranks second only to Texas in the percentage of its citizens who are uninsured. New Mexico is also the only state in the country with less than half of its population having private health insurance coverage.

A rather shocking statistic, which also continues to worsen, is that one out of every three Hispanic citizens are uninsured. In fact, less than 43 percent of the Hispanic population now has employer-based coverage nationwide, which is in sharp comparison to the 68 percent of non-Hispanic whites who have employer-based coverage.

The State has also enacted its own health reform plan called the State Coverage Initiative, or SCI in July 2005. SCI is a public/private partnership that is intended to expand employer-sponsored insurance and was developed in part with grant funding from the Robert Wood Johnson Foundation. As of May 1, there were just over 4,500 people covered by this initiative and there are efforts to expand this effort to cover over 20,000 individuals. With federal support for my State, the hope would be to further expand coverage to as many New Mexicans as possible.

It is also important to note that the legislation encourages reforms at both the state and local levels of government. Senator VOINOVICH, as former Mayor of Cleveland, suggested language that would capture community-based efforts as well. Illinois, Georgia, Michigan, and Oregon have all initiated efforts at the local level for reform, including what is known as the ''three-share'' programs in Illinois and Michigan. These initiatives have employers, employees, and the community each pick up about one-third of the cost of the program.

Jeaneane Smith, deputy administrator in the Office of Oregon Health Policy and Research was quoted in a recent Academy Health publication saying, ''In recent years it has become apparent that there is a need to consider both state- and community-level approaches to improved access. We want to learn how best to support communities as they play an integral part in addressing the gaps in coverage.''

Our hope is to spawn as much creative innovation as possible. Brookings Institute Senior Health Fellow Henry Aaron and Heritage Foundation Vice President Stuart Butler wrote a Health Affairs article in March 2004 that lays out the foundation for this legislative effort. They argue that while we remain unable to reconcile how best to expand coverage at the federal level, we can agree to support states in their efforts to try widely differing solutions to health coverage, cost containment, and quality improvement. As they write, ''This approach offers both a way to improve knowledge about how to reform health care and a practical way to initiate a process of reform. Such a pluralist approach respects the real, abiding differences in politics, preferences, traditions, and institutions across the nation. It also implies a willingness to accept differences over an extended period in order to make progress. And it recognizes that permitting wide diversity can foster consensus by revealing the strengths and exposing the weaknesses of rival approaches.''

The most important message that I hope this bill carries is that we must stop having the perfect be the enemy of the good. This proposal is certainly not perfect but we hope it makes a very

important contribution to addressing our nation's health care crisis.

In addition to Dr. Garson, Mr. Aaron, Mr. Butler, and Dr. Frisof, I would like to express my appreciation to Dan Hawkins at the National Association of Community Health Centers, Bill Vaughan at Consumers Union, and both Jack Meyer and Stan Dorn at ESRI for their counsel and guidance on health reform and this legislation.

I would also like to commend the American College of Physicians, or ACP, for their outstanding leadership on the issue of the uninsured and for their willingness to support a variety of efforts to expand health coverage. ACP has been a longstanding advocate for expanding health coverage and has authored landmark reports on the important role that health insurance has in reducing people's morbidity and mortality. In fact, to cite the conclusion of one of those studies, ''Lack of insurance contributes to the endangerment of the health of each uninsured American as well as the collective health of the nation.''

And finally, I would also thank the many people at the Robert Wood Johnson Foundation on their forethought and knowledge on all the issues confronting the uninsured. Their efforts to maintain the focus and dialogue on addressing the uninsured has kept the issue alive for many years.

I hope we can break the gridlock and urge my colleagues to support this important legislation.

I would ask for unanimous consent for a Fact Sheet and copy of the Health Affairs article entitled ''How Federalism Could Spur Bipartisan Action on the Uninsured'' be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE HEALTH PARTNERSHIP ACT

Introduced by Senators Voinovich and Bingaman in May 2006—''A bill to provide for innovation in health care through state initiatives that expand coverage and access and improve quality and efficiency in the health care system.''

The Health Partnership Act, cosponsored by U.S. Senators Voinovich (R–OH) and Bingaman (D–NM), is a first step to move beyond the political deadlock that has prevented the United States from finding paths to affordable, quality health care for all. For decades, national solutions have proven impossible to attain because of sharp differences on how to pay for and organize health care services. The Health Partnership Act breaks through the impasse. It creates partnerships among the federal government, state governments, private payers and health care providers to implement different approaches to achieve sustainable reform that provides affordable, quality health care for all. It demonstrates federal leadership on health care through establishing a mechanism by which federal dollars are committed to states to reduce the number of uninsured and to improve the quality of health care for all.

A creative new bipartisan initiative to move beyond political deadlock and a potential first step towards affordable quality health care for all.

THE FEDERAL LEVEL

Federal dollars will fund five-year State Health Care Expansion and Improvement Grants. The amount of federal funding for new grants will be determined annually in the budgetary process.

The bill establishes a bipartisan State Health Innovation Commission composed of national, state and local leaders that will:

Issue requests for proposals.

Establish, in collaboration with an organization such as the Institute of Medicine, minimum performance standards and 5-year goals.

Provide states with a ''toolkit'' of reform options, such as single-payer systems, public program expansions, pay-or-play mechanisms, tax credit incentives, health savings accounts, etc.

Ensure the maintenance of Medicaid—prohibiting restrictive rule changes that would limit eligibility or benefits.

Recommend to Congress which grants to support, giving preference to states maximizing the reduction in numbers of the uninsured.

Monitor the progress of programs and promote information exchange on what works.

Recommend ways to minimize negative effects on national employer groups, providers and insurers related to differing state requirements.

STATE LEVEL

Each state applying for a grant will develop a health care plan to increase coverage, improve quality and reduce costs, with specific targets for reduction in the number of uninsured and the costs of administration.

States will receive renewable grants for five-year expansion and improvement programs.

States will receive from the federal level technical assistance, if requested, for developing proposals.

Each state plan would address:

Coverage by describing the process and setting a 5-year target for reducing the number of uninsured individuals in the state.

Quality by providing a plan to increase health care effectiveness, efficiency, timeliness, and equity while reducing health disparities and medical errors.

Costs by developing and implementing systems to improve the efficiency of health care, including a 5-year target to reduce administrative costs and paperwork burdens.

Information technology by designing the appropriate use of health information technology to improve infrastructure, to expand the availability of evidence-based medical and to provide outcomes data to providers and patients.

STATES IN THE LEAD: LESSONS ON THE PROCESS OF MAKING CHANGE

Given the inaction of the federal government on health care access issues, states have begun to address these challenges creatively with sensitivity to local ideas and conditions. Dozens of states are considering new proposals. Five have already acted.

Maine, June 2003—the Dirigo Health Plan.

California, October 2003—phased-in Employer Mandate (repealed by ballot initiative, November 2004).

Illinois, September 2005—Health Care for All Children.

Maryland, January 2006—Fair Share Health Care (employer mandate for the largest employers).

Massachusetts, April 2006—Massachusetts Health Reform Package—with both an individual and an employer mandate.

The recently passed Massachusetts law deserves special attention because it is the first one enacted cooperatively with a divided government—a strongly Democratic state legislature and a Republican governor.

The detailed policy particulars in each of these state measures are controversial, with strong supporters and strong detractors. But they teach us a lot about the process of reforming health care in America.

State political leadership at the highest level is necessary.

Active consumer advocacy plays an important role.

Some stakeholder leadership must be willing to put the larger public interest above their own narrow economic self-interest.

The proposals have implementation phased in over several years.

It is easier for these proposals to expand access than to restrain the growth of costs—the latter being critical to make them sustainable over the long term.

Massachusetts, in particular, demonstrated how modest federal financial incentives (in this case the threatened loss of less than 1/10 of federal Medicaid funding) can provide the critical stimulus for leaders to come together to create comprehensive reform.

POLITICAL ADVANTAGES OF THE HEALTH PARTNERSHIP ACT

The Health Partnership Act provides positive multi-year financial incentives to states to address these issues, making it more likely for them to take the first steps and less likely to backslide when money concerns arise.

Congress need not pick just one path to health care for all. Members may be willing to let other states try models that they would oppose in their home states.

Allowing states to design their own plans, based on simple federal standards, has the potential to break through the current political deadlock. Breakthroughs in some states could be replicated elsewhere.

Advocacy is needed concurrently at the state and federal levels, with each reinforcing the other.

Federal support has the potential to counteract likely opposition by special interests in state efforts.

POLICY ADVANTAGES OF THE HEALTH PARTNERSHIP ACT

The process of implementing a variety of partnerships recognizes that one national plan may not address the differences among states and encourages states to address creatively their own needs.

Lessons learned in testing diverse state plans would benefit other states and national reform.

HOW FEDERALISM COULD SPUR BIPARTISAN ACTION ON THE UNINSURED

(By Henry J. Aaron and Stuart M. Butler)

Nearly everyone thinks that something should be done to reduce the number of Americans lacking health insurance. Unfortunately, while numerous plans exist on how to reach that goal, few agree on any one. In deed, as authors we disagree on how best to extend and assure health insurance coverage. Nonetheless, we believe that using the pluralism and creative power of federalism is the best way to break the political logjam and to discover the best way to expand coverage.

Accordingly, we believe that states should be strongly encouraged to try any of a wide range of approaches to increasing health insurance coverage and rewarded for their success. This approach offers both a way to improve knowledge about how to reform health care and a practical way to initiate a process of reform. Such a pluralist approach respects the real, abiding differences in politics, preferences, traditions, and institutions across

the nation. It also implies a willingness to accept differences over an extended period in order to make progress. And it recognizes that permitting wide diversity can foster consensus by revealing the strengths and exposing the weaknesses of rival approaches.

Despite our abiding disagreements on which substantive approach to extending coverage is best, we believe that people of goodwill must be prepared to countenance the testing of ideas they oppose if progress is to be made. Moreover, we believe that there is no hope for legislation to begin to transform the largest U.S. industry—health care—unless such legislation enjoys strong support from both major political parties.

USING FEDERALISM TO SPUR ACTION

Proposals to reduce the number of uninsured Americans abound. Some favor expanding government programs, such as Medicaid. Others favor refundable tax credits to help families buy private health insurance. Still others favor regulatory approaches, such as changes in insurance rules. But working together in health care to achieve a goal shared by virtually everyone has proved to be impossible. One reason for this is that the capacity to reach substantive compromise in Washington has seriously eroded. Among the causes is the widespread view that reforming the complex health care system requires very carefully designed and internally consistent actions. Some say that it is like building a new airplane: Unless all the key parts are there and fit together perfectly, the airplane will not fly. Thus, many proponents of particular approaches fear that abandoning key components of their proposals to achieve a compromise will prevent a fair test of their favored approach and lead to failure. Another obstacle is that many lawmakers believe that approaches that might conceivably work in one part of the country, given the cultural, philosophical, or health industry conditions prevailing there, will not work in their state or district because of different local conditions. This view leads many in Congress to resist proposals that might work in some areas because they believe that those proposals could make things worse for their constituents.

These and other factors have stalled efforts to extend health insurance and achieve other reforms for decades. The enactment of Medicare and Medicaid stands as one notable—and instructive—exception to that pattern. Medicare sprang from comprehensive social insurance initiatives of congressional Democrats, Medicaid from limited needs based approaches of congressional Republicans. The passage of each program was possible only because the two initiatives were linked in the form of a trade-off, not so much by blending some elements of each approach but by moving forward with two programs in parallel: Medicare for the elderly and disabled, and Medicaid for the poor of all ages. That experience illustrates a principle of politics: that progress often requires combining elements of competing proposals into a hybrid legislative initiative, in which internally consistent approaches operate in parallel.

In our view, federalism offers a promising approach to the challenge of building support to tackle the problem of uninsurance. While proponents of nationwide measures to introduce health insurance tax credits, or to extend Medicare or the State Children's Health Insurance Program (SCHIP) to other groups, should of course continue to make their case for national policies, we emphasize an initiative designed to support states in launching a variety of localized initiatives. Under this process, the federal government would reward states that agreed to test comprehensive and internally consistent strategies that succeeded in extending coverage within their borders. In contrast to block grants, federal-state covenants would operate within congressionally specified policy constraints designed to achieve national goals for extending health insurance. These covenants would include plans ranging from heavy government regulation to almost none, as long as the plans were consistent with the broad goals and included specified protections. States could also select items from a federally designed ''policy toolbox'' to include in their proposals. Allowable state plans would include forms of single-payer plans, employer mandates, mandatory individual purchase of privately offered insurance, tax credits, and creative new approaches. States would be free not to undertake such experiments and continue with the current array of programs, but sizable financial incentives would be offered to those that chose to experiment and financial rewards given to those that achieve agreed-upon goals.

The model we propose builds upon proposals we have outlined elsewhere. It is also compatible with some other federalism approaches, such as the plan advanced by the Institute of Medicine. We favor a wide diversity of federal-state initiatives for three reasons. First, fostering a bold program in a state will produce much information that will aid the policy discovery process. Successes will encourage others to follow, while unanticipated problems will force redesign or abandonment and will be geographically contained. Second, encouraging bold state action will quickly and directly extend coverage to many of the uninsured. Instead of facing continued national inaction or the potential for disruption of state initiatives by future federal action, states would have the incentive and freedom to act decisively. Third, we see no evidence of an emerging consensus on how to deal with these problems at the national level. But our proposal is based on the observation that advocates of rival plans trust their preferred approaches enough to believe that a real-life version would persuade opponents and create a consensus. Not all can be right, of course, but all advocates of health insurance reform, like residents of Lake Wobegon, seem to believe that their plans are above average. Thus, they should be open to the idea of testing diverse proposals. Our proposal is a process to enable policymakers to discover which is right, either for the whole country or for a region.

CORE ELEMENTS

We propose that Congress provide financial assistance and a legal framework to trigger a diverse set of federal-state initiatives. To help break the impasse in Congress over most national approaches, we propose steps designed to enable ''first choice'' political ideas to be tried in limited areas, with the support of states and through the enactment of a federal ''policy toolbox'' of legislated approaches that would be available to states but not imposed on them. Our view is that elected officials would be prepared to authorize some approaches now bottled up in Congress if they knew that the approach would not be imposed on their states. Our proposed strategy would contain six key elements.

Goals and protections. First, Congress would set certain goals and general protections. Goals would be established for extending coverage, and perhaps improving the coverage of some of those with inadequate coverage today. One such goal could be a percentage reduction in the number of uninsured people in a state. The more precise the goals, the more contentious they are likely to be. But clear and measurable goals under the proposed covenants are necessary if the system of financial rewards described below is to work effectively.

What is ''insurance''? For a coverage goal to mean anything, it would have to define what constitutes ''insurance.'' Specifying adequate coverage in health care is no easier than quantifying an adequate high school education, and when money follows success, drafting such definitions becomes even more difficult.

In defining what is meant by adequate insurance, agreement on two characteristics is vital: the services to be covered and the maximum residual costs (deductibles and copayments) that the insured must bear. States could be more generous than these standards. Instead of speciying precisely what states must do in each of these dimensions, we suggest that Congress establish a required actuarial minimum—such as the cost of providing the benefit package of the Federal Employees Health Benefits Program (FEHBP) for the state's population—as the standard, with states retaining considerable latitude on which services to include and how much cost sharing to require. Whether to set this actuarial standard high or low will be controversial and will determine the overall cost to the federal government of eliciting state participation.

Both high and low benefit standards suffer from well-known problems. High standards would raise program costs and weaken individuals' incentives to be prudent purchasers of health care. Low standards expose patients to sizable financial risk and raise questions about whether to restrict patients' right to buy supplemental coverage. Thus, federal legislation would not specify the content of insurance plans beyond some such actuarial amount. States would then be free to design plans as they wish, although certain types of plans might be presumptively acceptable (see below), and others could be negotiated as part of a covenant. The exact mix of benefits could vary within reason, but no further limits would be imposed. One goal of this approach, after all, is to encourage experimentation to generate information on whether particular configurations of benefits work better than others. It might turn out, for example, that states would adopt quite different plans with similar actuarial values. One group might opt for high deductible plans covering a wide range of services with no cost sharing above the deductible and generous relief from the deductible for the poor, while others might adopt a system with low deductibles and modest cost sharing but covering a much narrower range of benefits. Discovering how individuals' and providers' attitudes and behavior differ under such plans and how health outcomes vary would provide valuable information for private health insurance planners and government officials.

Protections for individuals. In addition to the definitional question, the question also arises, What limitations and protections should be applied to state experiments? If a simple net reduction in uninsurance guaranteed a financial reward to a state, for example, the state would have the incentive to drop coverage of costly high-risk adults and extend coverage to less costly (healthier and younger) workers. Some such concerns could be addressed in negotiating covenants, but some broad protections and policy ''corridors'' would be established under our proposal and would be necessary to achieve political support.

One of the most politically sensitive would be a primum non nocere limitation. That is, states could not introduce a plan that reduced coverage for currently insured populations, most notably the Medicaid population, beyond some minimum amount. We believe that no reform proposal is likely to

be achievable without that restriction. Most Medicaid outlays in many states are not strictly mandated by federal law, in the sense that some beneficiaries and some services for all beneficiaries are optional. States provide optional coverage because federal law permits it, and the federal match makes its provision attractive to states. If incentives were introduced to cover the non-Medicaid population, states might find it financially and politically attractive to increase the total number of insured people by curtailing Medicaid eligibility and benefits and using the money saved, together with federal support, to cover a larger number of people who are uninsured but less poor.

Designing and enforcing rules to prohibit or limit such ''insurance swapping'' would be extremely challenging but politically—and, one could argue, morally—essential. On the other hand, we believe that states should have some opportunity to propose different ways of delivering the Medicaid commitment to the currently insured population, as long as the degree and quality of coverage were not diminished. That form of Medicaid protection could stimulate creativity and improvement in coverage for the poorest citizens while avoiding any threat to their existing coverage. To be sure, there are disagreements, including between us, on the degree of freedom states should have in deciding how to deliver the Medicaid commitment. Positions range from only minor tweaking to sweeping changes in the delivery system, such as allowing states to use Medicaid money to subsidize individual enrollment in an equivalent private plan. The degree of flexibility states should have, while maintaining eligibility and level of coverage, is a difficult political issue for Congress to decide.

Acceptable state proposals would also have to limit cost sharing and features analogous to pension nondiscrimination rules. We believe that requirements, consistent with the general goals and protections we propose, are needed to ensure that lower-income households do not face unaffordable coverage. Without such limits, states could reduce the number of uninsured people and secure attendant federal financial support, for example, by instituting an individual mandate with a high premium that would effectively make insurance universal among the financially secure and do little for the poor. States would need to propose a fair, plausible way of meeting the requirement, such as by mandating some form of community rating or through a cross-subsidy to more vulnerable populations.

The federal government should establish broad guidelines, but no more. A key principle of our proposal is that state officials are more likely than federal officials to design successful solutions to those problems that members of the policy or congressional staff community have failed to solve. Congress can and should set the parameters, but it should avoid micromanagement.

''Policy toolbox'' of federal policies and programs. A feature of the congressional impasse noted earlier is that many plausible health initiatives that might merit testing, and have support in some states, are blocked by other lawmakers who oppose the introduction of the approach in their own state or across the country. Thus, we propose that Congress enact presumptively legitimate approaches to the expansion of health insurance coverage as a ''policy toolbox'' that would be available to states a la carte to apply within their borders. Lawmakers could safely vote to permit an initiative, confident that it would not be imposed on their states. In this way, potentially useful policies and programs could be ''unlocked'' from Congress and become available for states to use in their own initiatives.

A policy toolbox likely would include expansions of existing policies, such as raising income limits under Medicaid or lowering the age of Medicare eligibility. It could include arrangements to subsidize individual buy-ins to the FEHBP, refundable tax credits or their equivalent (perhaps with some steps to modify the federal income tax exclusion for employee-sponsored health insurance costs), mandating employer or individual coverage, or creating a single state insurance plan though which everyone may buy subsidized coverage.

Other possible examples might include the following: (1) Remove regulatory and tax obstacles to churches, unions, and other organizations providing group health insurance plans. This could open up new forms of group coverage offered though organizations with an established membership and common values. (2) Allow Medicaid and SCHIP to cover additional populations, with greatly enhanced federal matching payments, and perhaps to operate in very different ways—with appropriate safeguards to protect those who are covered under current law. Both federal welfare legislation and SCHIP, for example, included safeguards to preserve existing Medicaid coverage. (3) Extend limited federal Employee Retirement Income Security Act (ERISA) protection to large corporate health plans willing to enroll nonemployees, and extend the tax exclusion to those enrollees. This could lead in a state to expanded access to comprehensive coverage. (4) Provide a voucher to individuals designed to mimic a comprehensive refundable tax credit for health insurance. This could allow the practical issues of a major tax credit approach to be examined. (5) Enact legislation to make forms of FEHBP-style coverage available to broader populations within states. This would enable states and federal government to explore the issues associated with extending the program to nonfederal employees and retirees. (6) Enable states to establish association plans and other innovative health organizations.

We emphasize that any menu of tools would be optional for states. None would be required. Members of Congress would be more likely to agree to the inclusion of elements they would deplore in their own states if they knew that no state, including their own, would be forced to adopt them than they would be in a nationally uniform system. Some lawmakers, for instance, oppose association plans be cause they believe that such plans would disrupt successful state insurance arrangements. Under the menu approach, association plans would be introduced only in states wishing to use them as part of their overall strategy.

State proposals, federal approval. Under our proposed strategy, states interested in a bold, creative initiative would design a proposal consistent with the goals and restrictions established by Congress. Typically this proposal would include some elements from the federal policy toolbox in conjunction with state initiatives.

Needless to say, a critical congressional decision would concern mechanisms for approving state plans and monitoring state performance. States would no doubt seek to take advantage of every financial opportunity to game the system and to stretch agreements to the limit, as the almost zany history of the Medicaid upper payment level (UPL) controversy makes painfully clear. Yet monitoring state behavior, determining state violations, and enforcing penalties on states is enormously difficult. Moreover, the entity could (and we think should) have the power to negotiate parts of a proposal, not merely approve or reject it, so that refinements could be made consistent with Congress's objectives.

But what entity should this be? It might seem natural to designate an executive agency that reports to the president, such as the Department of Health and Human Services (HHS). We suspect, however, that many members of Congress would refuse to cede so much selection authority to another branch of government and that roughly half would fear partisan decisions by an administration of the ''other'' party. Congress would likely insist on adding suffocating selection criteria and other restrictions to executive department decisions, jeopardizing the very creativity we intend. Thus, we favor instead an existing or newly created body that has independence but ultimately answers to Congress. A new bipartisan body might perform this function with members selected by Congress and the administration or with members also representing the states, with technical advice from the U.S. Government Accountability Office (GAO). This body would evaluate and negotiate draft state proposals according to the general requirements specified by Congress and then present a recommended ''slate'' of proposals to Congress for an up-or-down vote without amendment. Once the state proposals had been selected, HHS would be responsible for implementing the program.

Bipartisan willingness to authorize state programs and to appropriate sufficient funds to elicit state participation also requires that members of Congress believe that approaches they find congenial will receive a fair trial and agree that approaches they reject will also receive a fair trial. Unfortunately, current federal legislation makes two key approaches difficult to implement in individual states or even groups of states: a single-payer plan and an individual mandate combined with refundable tax credits. A federalist approach should include mechanisms that would enable states to give such proposals as fair and complete a test as possible, both because that would provide valuable information and because the political support of their advocates is important in Congress.

Crafting a single-payer experiment. ERISA, which exempts self-insured plans from state regulation, is the primary technical obstacle to testing single-payer plans. The political sensitivity to modifications in ERISA is difficult to exaggerate. Any attempt to carve out an exception from ERISA for state programs to extend cover age would probably doom federal legislation. But states could create ''wrap around'' plans to cover all who are not currently insured, or even to cover all who are not insured under plans exempted by ERISA from state regulation. While such an arrangement would not be a single-payer plan, it could achieve universal coverage, which is one defining characteristic of single-payer plans, and arguably be sufficient for a valid test. After all, the U.S. health care system is characterized by different subsystems for certain populations and has a form of single-payer coverage for military veterans. But of course the real test is whether advocates of single-payer plans regard such a limited arrangement as a fair trial.

An individual tax credit approach. The obstacles to a state level individual mandate with a refundable credit are also serious and complicated. We presume that an individual mandate would require some contribution from people with incomes above defined levels. Such a mandate raises both political and practical questions. Testing federal tax reform in selected geographic areas also raises constitutional and practical issues, although advocates of the approach maintain that other site-specific programs involving federal tax changes, such as enterprise zones,

have passed muster. In addition, for a limited experiment it might be possible to design subsidy programs that would mimic tax relief.

Administering a refundable tax credit would pose formidable difficulties for some states, particularly those that do not have a personal income tax. In all states, the logistics of providing a credit with reasonable accuracy on a timely basis would be challenging. So, too, would deciding how to address such administrative problems as households that live in one state yet work in another. Advocates for tax credits say they have solutions to these and similar challenges, just as supporters of single-payer approaches or employer mandates claim to have answers to challenges facing those approaches. For instance, some maintain that the employment-based tax withholding system could serve as a vehicle for refundable credits or equivalent subsidies and would make individual enrollment practical. Whether or not they are right is of course disputed by their critics. The beauty of a ''put up or shut up'' federalism initiative is that it offers a chance for advocates to offer such solutions in practice instead of in theory.

Using ''managed federalism'' to build support? Deciding how many states could qualify for experiments is an open political and technical question. One approach would be to limit it to a few states. This would limit costs but has little else to be said for it. Accordingly, we would favor opening the program to all states wishing to accept a federal offer. Nevertheless, we recognize that some lawmakers would be reluctant to vote for a process of federal-state innovation unless they were sure that certain ''generic'' or ''standard'' approaches were included—especially if the number of states in the program were to be limited. In particular, we believe that our proposal can win congressional support only if liberals and conservatives alike are fully convinced that the approaches each holds dear will receive a fair and full trial in practice.

While we believe that any state initiative that meets approval should be welcomed, political considerations thus might require that no state's proposal would be approved unless a sufficient range of acceptable variants was proposed. For example, strong advocates of market-based or single-payer approaches might find the federalism option acceptable only if each was confident that favored approaches would be tested.

Adequate data collection. To determine whether a state was actually making progress toward a goal, accurate and timely data would be needed. These data would include surveys of insurance coverage, with sufficient detail to provide state-level estimates. Such surveys would be essential to show whether the states were making progress in extending health insurance coverage. They are vital to the success of the whole approach because payments to states (apart from modest planning assistance) should be based on actual progress in extending coverage, not on compliance with procedural milestones.

Congress should also assure that states report on use of health services, costs, health status, and any other information deemed necessary to judge the relative success of various approaches to extending coverage. Only a national effort could ensure that data are comparable across states. States' cooperation with data collection would be one element of the determination of whether a state was in compliance with its covenant and was therefore eligible for full incentive payments. The experience with state waivers under welfare before enactment of the 1996 welfare reform clearly illustrates the power and importance of such data collection. The cumulative effect of the reports showing the effectiveness of welfare-to-work requirements in reducing rolls, increasing earnings, and raising recipients' satisfaction transformed the political environment and made welfare reform inescapable.

Rewarding progress. Congress would design a formula under which states would be rewarded for their progress in meeting the agreed federal-state goals of extending insurance coverage. As experience with countless grant programs attests, haggling over such formulas can become politics at its grubbiest, with elected officials voting solely on the basis of what a particular formula does for their districts. Even without political parochialism, designing a formula that rewards progress fairly is no easy task. For one thing, states will be starting from quite different places. The proportion of states' uninsured populations under age sixty-five during 1997–1999 ranged from 27.7 percent in New Mexico and 26.8 percent in Texas to 9.6 percent in Rhode Island and 10.5 percent in Minnesota and Hawaii. Designing an incentive formula to reward progress amid such diverse conditions is both an analytical and a political challenge. Moreover, the per capita cost of health care varies across the nation, which further complicates the assessment of progress. The cost of extending coverage depends on the geographic location, income, and health status of the uninsured population. Having financial access may be hollow in communities where services are physically unavailable or highly limited. Extending coverage may require supply-side measures to supplement financial access.

We believe that the only way to design such a formula is to remove the detailed design decisions from congressional micromanagement. We suggest that Congress be asked to adopt the domestic equivalent of ''fast-track'' trade negotiation rules or base-closing legislation. Under this arrangement, Congress would designate a body appointed in equal numbers by the two parties, to design an incentive formula that Congress would agree to vote up or down, without amendments. Such a formula would have to recognize the different positions from which various states would start. Any acceptable formula would have to reward both absolute and relative reductions in the proportions of uninsured people. Whether financial incentives would be offered for other dimensions of performance and how performance would be measured constitute additional important challenges.

Sources of funding. Bleak budget prospects could cause one to give up on this or any other attempt to extend health insurance coverage broadly. But as recent history amply illustrates, the political and budgetary weather can change dramatically and with little notice. What funding approach would be desirable if funds were available? Under our proposal, the federal funding would be intended for several broad purposes: (1) A large portion of the money would be used to help states actually fund approaches to be tested. (2) Some funding (perhaps with assistance from private foundations) would provide national support and technical assistance to states. A model to consider for such support is the Health Resources and Services Administration (HRSA) State Planning Grants program, which both funds state planning activities and provides federal support and technical assistance. (3) Some funds would cover the cost of independent performance monitoring. (4) Some funds would be set aside to reward states for meeting the goals in their agreed-upon plan. Congress might consider an automatic ''performance bonus'' system similar to the mechanism used in welfare reform. Congress could also consider withholding the periodic release of part of a state's grant pending a periodic assessment by the independent monitor of the degree to which the state is accomplishing the objectives specified in its covenant. Only those states willing to offer proposals designed to achieve the national goals would be eligible for a share of the funding or for the menu of federal policy tools. A state could decline to offer a proposal and remain under current programs.

Federalism enables the states to undertake innovative approaches to challenges facing the United States. Federal legislation often grants states broad discretion in designing even those programs for which the federal government bears much or most of the cost. In health care as well as education or welfare, states have been the primary innovators. But the federal government limits, shapes, and facilitates such innovation through regulation, taxation, and grants. Such a partnership is bound to be marked by conflict and tension as state and federal interests diverge.

A creative federalism approach of the kind we propose would change the dynamics of discovering better ways to expand insurance coverage, just as a version of this approach triggered a radical change in the way states addressed welfare dependency. By actually testing competing approaches to reach common goals, rather than endlessly debating them, the United States is far more likely to find the solution to the perplexing and seemingly intractable problem of uninsurance.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 471—RECOGNIZING THAT, DURING NATIONAL FOSTER CARE MONTH, THE LEADERS OF THE FEDERAL, STATE, AND LOCAL GOVERNMENTS SHOULD PROVIDE LEADERSHIP TO IMPROVE THE CARE GIVEN TO CHILDREN IN FOSTER CARE PROGRAMS

Mr. COLEMAN (for himself, Ms. LANDRIEU, and Mr. CRAIG) submitted the following resolution, which was considered and agreed to:

S. Res 471

Whereas more than 500,000 children are in foster care programs throughout the United States;

Whereas, while approximately ¼ of all children in foster care programs are available for adoption, only about 50,000 foster children are adopted each year;

Whereas many of the children in foster care programs have endured—

(1) numerous years in the foster care system; and

(2) frequent moves to and from foster homes;

Whereas approximately 50 percent of foster care children have been placed in foster care programs for longer than 1 year;

Whereas 25 percent of foster care children have been placed in foster care programs for at least 3 years;

Whereas children who spend longer amounts of time in foster care programs often experience worse outcomes than children who are placed for shorter periods of time;

Whereas children who spend time in foster care programs are more likely to—

(1) become teen parents;

(2) rely on public assistance when they become adults; and

(3) interact with the criminal justice system;